

The yeas and nays are mandatory. The clerk will call the roll.

The bill clerk called the roll.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 56, nays 44, as follows:

[Rollcall Vote No. 291 Leg.]

YEAS—56

Abraham	Gorton	McConnell
Allard	Gramm	Murkowski
Ashcroft	Grams	Nickles
Bennett	Grassley	Roberts
Bond	Gregg	Roth
Brownback	Hagel	Santorum
Burns	Hatch	Sessions
Campbell	Helms	Shelby
Coats	Hutchinson	Smith (NH)
Cochran	Hutchison	Smith (OR)
Collins	Inhofe	Snowe
Coverdell	Jeffords	Specter
Craig	Kempthorne	Stevens
D'Amato	Kyl	Thomas
DeWine	Lieberman	Thompson
Domenici	Lott	Thurmond
Enzi	Lugar	Torricelli
Faircloth	Mack	Warner
Frist	McCain	

NAYS—44

Akaka	Durbin	Lautenberg
Baucus	Feingold	Leahy
Biden	Feinstein	Levin
Bingaman	Ford	Mikulski
Boxer	Glenn	Moseley-Braun
Breaux	Graham	Moynihan
Bryan	Harkin	Murray
Bumpers	Hollings	Reed
Byrd	Inouye	Reid
Chafee	Johnson	Robb
Cleland	Kennedy	Rockefeller
Conrad	Kerrey	Sarbanes
Daschle	Kerry	Wellstone
Dodd	Kohl	Wyden
Dorgan	Landrieu	

The PRESIDING OFFICER. On this vote the yeas are 56, the nays are 44. Three-fifths of the Senators duly chosen and sworn not having voted in the affirmative, the motion is rejected.

Mr. LOTT. Mr. President, I move to reconsider the vote and I move to table the motion.

The motion to lay on the table was agreed to.

MORNING BUSINESS

Mr. LOTT. Mr. President, I ask unanimous consent that there now be a period for morning business until the hour of 12:30 p.m., with Senators permitted to speak for up to 10 minutes each, with the time equally divided between the two leaders or their designees.

Following morning business, the Senate would then stand in recess under the previous order until 2:30 p.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LOTT. Therefore, the next rollcall vote would occur at 2:30 p.m. That vote would be on the cloture motion with respect to the motion to proceed to the fast-track legislation.

I yield the floor.

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Senator from Maine.

ADVANCE PLANNING AND COMPASSIONATE CARE ACT

Ms. COLLINS. Mr. President, last week I was pleased to join with my colleague from West Virginia, Senator ROCKEFELLER, in introducing S. 1345, the Advance Planning and Compassionate Care Act which is intended to improve the way we care for people at the end of their lives.

Noted health economist Uwe Reinhardt once observed that "Americans are the only people on earth who believe that death is negotiable." Advancements in medicine, public health, and technology have enabled more and more of us to live longer and healthier lives. However, when medical treatment can no longer promise a continuation of life, patients and their families should not have to fear that the process of dying will be marked by preventable pain, avoidable distress, or care that is inconsistent with their values or wishes.

The fact is, dying is a universal experience, and it is time to reexamine how we approach death and dying and how we care for people at the end of their lives. Clearly there is more that we can do to relieve suffering, respect personal choice and dignity, and provide opportunities for people to find meaning and comfort at life's conclusion.

Unfortunately, most Medicare patients and their physicians do not currently discuss death or routinely make advance plans for end-of-life care. As a result, about one-fourth of Medicare funds are now spent on care at the end of life that is geared toward expensive, high-technology interventions, and rescue care. While four out of five Americans say they would prefer to die at home, studies show that almost 80 percent die in institutions where they may be in pain, and where they are subjected to high-technology treatments that merely prolong suffering.

Moreover, according to a Dartmouth study released earlier this month, where a patient lives has a direct impact on how that patient dies. The study found that the amount of medical treatment Americans receive in their final months varies tremendously in the different parts of the country, and it concluded that the determination of whether or not an older patient dies in the hospital probably has more to do with the supply of hospital beds than the patient's needs or preference.

The Advance Planning and Compassionate Care Act is intended to help us improve the way our health care system serves patients at the end of their lives. Among other provisions, the bill makes a number of changes to the Patient Self-Determination Act of 1990 to facilitate appropriate discussions and individual autonomy in making difficult discussions about end-of-life care. For instance, the legislation requires that every Medicare beneficiary receiving care in a hospital or nursing facility be given the opportunity to discuss end-of-life care and the preparation of an advanced directive with an

appropriately trained professional within the institution. The legislation also requires that if a patient has an advanced directive, it must be displayed in a prominent place in the medical record so that all the doctors and nurses can clearly see it.

The legislation will expand access to effective and appropriate pain medications for Medicare beneficiaries at the end of their lives. Severe pain, including breakthrough pain that defies usual methods of pain control, is one of the most debilitating aspects of terminal illness. However, the only pain medication currently covered by Medicare in an outpatient setting is that which is administered by a portable pump.

It is widely recognized among physicians treating patients with cancer and other life-threatening diseases that self-administered pain medications, including oral drugs and transdermal patches, offer alternatives that are equally effective in controlling pain, more comfortable for the patient, and much less costly than the pump. Therefore, the Advance Planning and Compassionate Care Act would expand Medicare to cover self-administered pain medications prescribed for the relief of chronic pain in life-threatening diseases or conditions.

In addition, the legislation authorizes the Department of Health and Human Services to study end-of-life issues for Medicare and Medicaid patients and also to develop demonstration projects to develop models for end-of-life care for Medicare beneficiaries who do not qualify for the hospice benefit, but who still have chronic debilitating and ultimately fatal illnesses. Currently, in order for a Medicare beneficiary to qualify for the hospice benefit, a physician must document that the person has a life expectancy of 6 months or less. With some conditions—like congestive heart failure—it is difficult to project life expectancy with any certainty. However, these patients still need hospice-like services, including advance planning, support services, symptom management, and other services that are not currently available.

Finally, the legislation establishes a telephone hotline to provide consumer information and advice concerning advance directives, end-of-life issues and medical decision making and directs the Agency for Health Care Policy and Research to develop a research agenda for the development of quality measures for end-of-life care.

The legislation we are introducing today is particularly important in light of the current debate on physician-assisted suicide. As the Bangor Daily News pointed out in an editorial published earlier this year, the desire for assisted suicide is generally driven by concerns about the quality of care for the terminally ill; by the fear of prolonged pain, loss of dignity and emotional strain on family members. Such worries would recede and support for assisted suicide would evaporate if